Authorization for Examination And/Or Treatment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

The following request for information is authorized by law (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108.

OMB No.: 1215-0103
Expires: 09-30-91

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

Memorial Hospital
1245 Main Street, Tucson, AZ 85714

2. Employee's Name (last, first, middle)	3. Date of Injury (mo. day, yr.)	4. Occupation
DAY, Donald L.	2-10-94	Electrician

5. Description of Injury or Disease:

Fell approximately 15 feet from scaffold -- Right ankle extremely painful.

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B. ☒ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

☐ 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official)	8. Signature of Authorizing Official:
N/A	9. Name and Title of Authorizing Official: (Type or print clearly) Ronald Cane Chief, Electrical Shop
10. Local Employing Agency Telephone Number: (602) 746-0001	11. Date (mo., day, year) 2-10-94
12. Send one copy of your report: (Fill in remainder of address) **U.S. DEPARTMENT OF LABOR** Employment Standards Administration Office of Workers' Compensation Programs 71 Stevenson Street, 2nd Floor San Francisco, CA 94105	13. Name and Address of Employee's Place of Employment: Department of Agency USAF Bureau or Office AWG Local Address (including Zip Code) 836 CSG/DPC Davis-Monthan AFB AZ 85707

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing burden, to the Office of Information Management, Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Form CA-16
Rev. Oct. 1988

Figure 810-22. Form CA-16 with Instructions.

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (last, first, middle)

DAY, Donald L.

15. What History of Injury or Disease Did Employee Give You?

Employee fell from scaffold-injured right ankle

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe)
☐ Yes ☒ No

16a. IDC-9 Code

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)

Sprained right ankle

18. What is Your Diagnosis?

18a. IDC-9 Code

19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt)
☒ Yes ☐ No

20. Did Injury Require Hospitalization? ☐ Yes ☒ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required? ☐ Yes ☒ No

22. Surgery (If any, describe type)

N/A

23. Date Surgery Performed (mo., day, year)

24. What (Other) Type of Treatment Did You Provide?

25. What Permanent Effects, If Any, Do You Anticipate?

26. Date of First Examination (mo., day, year)

2-10-94

27. Date(s) of Treatment (mo., day, year)

2-10-94

28. Date of Discharge from Treatment (mo., day, year)

Not Yet

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate)
Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee is Able to Resume Work, Has He/She been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. If Employee is Able to Resume Only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, if Indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No (If yes, state specialty)

35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowlingly made may subject me to felony criminal prosecution.

36. Address (No., Street, City, State, Zip Code)

37. Tax Identification Number

38. Date of Report

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim From" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

Figure 810-22. Form CA-16 Continued.

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical officer/hospital or any duly qualified physician/ hospital of the employee's choice.

  If the employee elects to be treated by a private physician, a copy of the American Medical Association standards billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

  A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

  Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

- Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL FACILITIES

- U.S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

DEFINITION OF INJURY

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF PHYSICIAN

- The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

FORM COMPLETION

- Part A shall be compelted in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item B. Check B1 or B2 or Item 6, whichever is appropriate. In case of illness or disease, only Box B2 may be checked.

  Show the address of the proper OWCP Office in Item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

- See 20 CFR and/or Chapter 810, Federal Personnel Manual (FPM).

Information for Physician - See Reverse Side

Figure 810-22 Continued

INFORMATION FOR PHYSICIAN

YOUR AUTHORIZATION

- Please read Part A of Form CA-16. You are authoreized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A, Item 12.

USE OF CONSULTANTS AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accomodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 38, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA 17, "Duty Status Report" may be required by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF RECORDS

- Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

BILLING FOR SERVICES

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified, in Column 24 C of the form, by the applicable Current Procedural Terminology (4th edition) Code CPT 4). A copy of the form may be supplid by the employee at the time treatment is sought.

- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION NUMBER

- The provider's Tax Identification Number (TIN) is an important identifier in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN - either corporate or personal - which is used consistently on OWCP claims.

ADDITIONAL INFORMATION

- Contact the OWCP shown in Item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.

Figure 810-22 Continued

Instructions for Completing Form CA-16, Request for Examination and/or Treatment

Part A - Authorization. The official authorized to issue the Form CA-16 completes Items 1 through 13. (Obtain the required information from the employee.)

Item 1. Enter the full name and address of the physician or hospital selected by employee only AFTER VERIFYING THAT THE PHYSICIAN IS NOT LISTED AS BEING AN EXCLUDED PROVIDER UNDER THE FECA PROGRAM - AND - AFTER AN APPOINTMENT HAS BEEN MADE BY THE ISSUING AUTHORITY.

a. If issued to cover emergency care after the fact, enter "EMERGENCY CARE PROVIDED."

b. If issued due to a recurrence and if a form CA-16 is authorized, the source of care should be the same medical provider that previously provided care to ensure continuity of treatment. FORM CA-16 SHOULD RARELY BE ISSUED IN CASES OF RECURRENCE. IT MAY NOT BE ISSUED IF MORE THAN 6 MONTHS HAS ELAPSED SINCE THE EMPLOYEE LAST RETURNED TO WORK OR TO AUTHORIZE A CHANGE OF PHYSICIAN AFTER THE INITIAL CHOICE HAS BEEN EXERCISED BY THE EMPLOYEE.

Item 2. Employee's last name, first name, middle name (enter "NMN" if no middle name.

Item 3. Enter date of original injury. See Item 10 on the Form CA-1.

Item 4. Enter the employee's job title.

Item 5. Provide a DESCRIPTION of the injury. This information can assist the doctor. Item 14 on the Form CA-1 may contain information that will be helpful in completing this item.

Item 6. Check block "6B1" if there is no doubt as to the validity of injury. Check block "6B2" if there is doubt.

Item 7. If the CA-16 is issued for treatment of an occupational disease claim, enter the name of the OWCP official who authorized the Form CA-16.

Items 8-9. Identify the supervisor authorized to issue the form - The form must be signed.

Item 10. Enter the supervisor's telephone number.

Item 11. Enter the date the Form CA-16 was issued.

Item 12. Add the address of the servicing office of OWCP. The ICPA will forward it to OWCP.

Item 13. Add the address of the civilian personnel office authorized to process medical reports.

Part B. Items 14 through 38 must be completed by the treating physician (See Figure 2-19- sample letter to physician advising of light duty program.)

NOTE: Any time a Form CA-16 is issued, it guarantees payment even if block 6B2 is checked and even if the claim is denied.

Figure 810-22. CA-16 with Instructions.

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Federal Employees Injured at Work

TO: Amos B. Jackson, M.D.
Street Address
City, State, Zip Code

Dear Dr Jackson:

Our employee, James O. Smith, has sustained a job-related traumatic injury on 25 May 1994 which may entitle him to benefits under the Federal Employees' Compensation Act.

Before the Office of Workers' Compensation Programs (OWCP) can make a decision on the claim, they must have comprehensive medical evidence from the physician providing treatment for the injury. Accordingly, we request that you complete the enclosed form and give it to our injured employee when you have finished your examination. A medical release form has been completed by our injured employee and is forwarded for your retention.

We are willing to accommodate partially disabled employees with suitable light- or limited-duty assignments. We can and will provide light- or limited-duty assignments in strict accordance with any physical limitations you impose. If you feel the employee cannot perform any type of work, please send us a prognosis of when return to work may be possible in either a limited or full capacity.

Please submit your bill on the enclosed billing form HCFA-1500 and return it in the self-addressed envelope.

Thank you for your time and cooperation. If I can be of any assistance, please call me at 522-0001.

Sincerely,

3 Encl
1. CA-16
2. HCFA-1500 w/Envelope
3. Med Release

MELVIN A. BROWN
Injury Compensation Program
Administrator

Figure 810-23. Sample Letter to Physician with CA-16.